STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G079	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-NORTH WILLOW	2002 W. 86TH ST. INDIANAPOLIS, IN46260

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W0000	This visit was for the investigation of Complaint #IN00095883. Complaint #IN00095883: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W154 and W210. Unrelated Deficiencies Cited. Survey dates: September 12, 13, 14, and 15, 2011. Facility Number: 000622 Provider Number: 15G079 AIM Number: 100272170 Survey Team: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor These deficiencies reflect state findings cited in accordance with 431 IAC 1.1. Quality Review completed 9/20/11 by Chris Greeney, ICF-ID Surveyor Supervisor and Ruth Shackelford, Medical Surveyor III.	W0000	DISCLAIMER STATEMENT Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal & State Law. "This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0154	The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 1 of 49 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to provide reproducible evidence/documentation of a thorough investigation of a client to client aggression/abuse incident involving clients B and C. Findings include: The facility's reportable incident reports/investigations were reviewed on 9/12/11 at 2:21 PM. The facility's 8/10/11 reportable incident report indicated "[Client C] noted to continually enter [client B's] room. He was also noted to strike [client B's] feeding pole and pull on [client B's] G-tube (Gastronomy feeding tube). Staff redirected [client C] many times with difficulty. [Client B] was moved to an alternate room on an another unit for protection. Investigation in peocess (sic)...." The facility's 8/10/11 Client To Client Investigation report indicated "...Client interviews: Clients that were interviewed	W0154	W 154 Staff Treatment of Clients The facility must have evidence that all alleged violations are thoroughly investigated. I Corrective Action for Cited Clients: Investigation of incident of 8-10-11 will be redone in order to be complete and accurate. The investigation will be reopened if appropriate. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: The HRC Director will be held accountable for tracking of investigations, completeness and all information submitted to QAA. IV Monitoring Corrective Measures:A daily QAA meeting is held with Client Advocates and Administration including Program Directors/Designee where each investigation is discussed including interviews and progress of the investigating process is reviewed. This includes review of thoroughness of investigations. To be completed by 10-15-11.	10/15/2011

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	reported that [client C] has come into some of their rooms as well. They report that he will just stand there beside them and look at them or will look out the window. Staff interviews: Staff reported re-directing [client C] numerous times from [client B's] room and other client's (sic) rooms as well. [Client B] is the only one that staff is aware of [client C] actually touching. Staff has never known of [client C] to pull on anyone's G-Tube prior to this incident. Conclusion: [Client B] was relocated temporarily to 1 South, now has been returned, [client C's] Risperdal (behavior medication) increased by additional mg (milligram), [client B] no longer on feeding pump...Many behaviors occurring during the day toward peers, running into offices and standing over people. It may take speaking in a firm voice in order to redirect him. Documentation is improving for [client C]. A new tally sheet has been formed and is being tracked daily each shift. This will provide the Psychiatrist with accurate information on [client C's] behaviors....Staff will continue to direct [client C] out of his peer's rooms when he is not approved to enter." The attached interviews with the 8/10/11 Client To Client investigation indicated client and staff interviews were conducted on 8/9/11 (incident 8/10/11). The 8/9/11 attached interviews did not match the above			

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	mentioned client to client incident involving clients B and C. The attached interviews with staff and clients were in regard to an investigation of involving an injury unknown origin with client C. Interview with administrative staff #3 on 9/14/11 at 12:50 PM indicated she conducted the investigation of the 8/10/11 incident involving clients B and C. Administrative staff #3 indicated clients and staff were interviewed in regard to the incident. Administrative staff #3 indicated she was not able to locate the actual interviews/documentation for the 8/10/11 investigation. This federal tag relates to complaint #IN00095883. 3.1-28(d)			
W0157	If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 49 incidents involving allegations of abuse, neglect and/or injuries of unknown origin, the facility failed to ensure the recommended corrective action was implemented/addressed to ensure client I's safety in regard to physical escorts to prevent injury. Findings include:	W0157	W157 Staff Treatment of Clients If the alleged violation is verified, appropriate corrective action must be taken. I Corrective Action for Cited Clients:	10/15/2011

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	The facility's reportable incident reports and/or investigations were reviewed on 9/12/11 at 2:21 PM. The facility's 8/29/11 reportable incident report indicated "[Client I] presented with 2 bruises noted by her CNA (Certified Nurse Aide) assisting with a shower. These bruises are to her right axillary area 2.5cm (centimeters), 1.5cm circular reddish purple in color...." The facility's undated Unknown Report indicated "...Conclusion: The bruising is directly where one might place their hand if they were doing an escort inappropriately. This could also be an area where someone placed his or her hand to guide [client I] along. The Coumadin (blood thinner) is the contributing factor allowing her to bruise easily. Appropriate techniques for escorts were retrained on 8-31-11 and 9-1-11...The team is also discussing the development of a uniform way to assist [client I] with ambulation. A way that will be least likely to cause a bruise but still allow for [client I] to feel secure in her guide." Interview with administrative staff #4 and Qualified Developmental Disabilities Professional (QDDP) #7 and the Social Service Coordinator (SSC) on 9/14/11 stated client I was "sensitive to touch." The SSC stated client I was blind and		Client I has a uniform method to address a uniform technique of ambulation. It has been implemented and trained with staff. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: IDTs are reviewed and signed by the Program Director who oversees tracking of implementation needed. IV Monitoring Corrective Measures: Client Advocate tracking will include receipt of follow up material as identified in the IDT when generated as part of an investigation. To be completed by 10-15-11.	

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	would "react aggressively" when touched. QDDP #1 indicated the recommendation/corrective action to develop a uniform way to assist the client to ambulate had not been addressed. 3.1-28(e)			
W0189	The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on interview and record review for 4 additional clients (G, H, I and J), the facility failed to ensure all staff who worked on the clients' units were re-trained in regard to appropriate techniques for physical intervention. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 9/12/11 at 2:21 PM. The facility's reportable incident reports and/or investigations indicated the following: -8/8/11 "Resident [client J] presented with superficial pink scratches to right upper anterior arm...." The facility's undated Unknown Report (investigation) indicated "...Conclusion: The team feels that the scratches to [client J's] right upper arm may be a result of redirecting him	W0189	W 189 Staff Training Program The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. I Corrective Action for Cited Clients: The individuals identified as needing to complete the training with regard to appropriate techniques for physical intervention have been trained. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: The CNA scheduler will maintain the list of regular assignments of CNA staff and that list will be distributed to ED/DNS and Program Director staff at a minimum when updated. IV Monitoring Corrective Measures: Program Directors will assure that all appropriate staff have been trained. To be completed by 10-15-11.	10/15/2011

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	using inappropriate techniques. [Client J] has escort written in his BSP (Behavior Support Plan) due to multiple AWOL (absence without leave), and wandering behaviors. The staff will be trained on escorts and redirecting to ensure that all staff are using the proper technique." -8/14/11 client G had bruising on her left and right upper arms of an unknown origin. The facility's undated Unknown Report (investigation) indicated "...Conclusion: When [client G] is in the manic phase of her bipolar disease, she may walk quickly and almost run, flailing her arms at the same time. staff (sic) try to prevent her from hitting during these times. She is difficult to redirect, and there are times that she may require a gentle touch assist by to her room (sic). staff (sic) are not intending but when she pushes into them she or she reaches out to hit, staff may exert more of a firm grip around her arm to maintain that immediate safety. The areas of bruising are where staff have been seen using a gentle touch to assist her and prevent her from falling and hitting when she is in the manic phase of her Bipolar disease...It is likely that the bruises could be from 0staff (sic) exerting a firm grip on her arms, without any intent to cause bruising. the interdisciplinary team has agreed that staff will be re-inserviced on escorts for [client			

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	G], and proper techniques to assist during these manic phases in order to provide safety for all of the clients...." -8/29/11 "[Client I] presented with 2 bruises noted by her CNA (Certified Nurse Aide) assisting with a shower. These bruises are to her right axillary area 2.5cm (centimeters), 1.5cm circular reddish purple in color...." The facility's undated Unknown Report indicated "...Conclusion: The bruising is directly where one might place their hand if they were doing an escort inappropriately. This could also be an area where someone placed his or her hand to guide [client I] along. The Coumadin (blood thinner) is the contributing factor allowing her to bruise easily. Appropriate techniques for escorts were retrained on 8-31-11 and 9-1-11...." -8/30/11 "Unknown Injury Resident (client H) presented with bruises to both upper arms. CNA observed and reported to nurse after shower...." The facility's undated Unknown Report indicated "...Conclusion: The team discussed the discoloration to [client H's] arms. The team feels that the bruising most likely was a result of an unapproved escort procedure. All CNA's (sic) as well as nurse's (sic) and QMRP's (Qualified Mental Retardation Professional's) (sic)			

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were retrained in proper restraint and escort procedures on 8/31 and 9/1/2011...."

The facility's 2011 Client Roster-Revised was reviewed on 9/12/11 at 2:00 PM. The client roster indicated the clients resided on the following units:

-client J on 2 North
-client G on 3 West
-client I on 3 West
-client H on 3 South

The facility's inservice records were reviewed on 9/14/11 at 1:16 PM. The facility's 8/31 and 9/1/11 Restraint Training records indicated facility staff were retrained in regards to "Therapeutic Physical Interventions" which included Punch Deflection," 1 person escort, 2 person escort, "brief hand hold," bear hug and a basket hold. The facility's 8/31 and/or 9/1/11 inservice training record indicated 2 staff (CNAs #10 and #11) had not been re-trained on 3 West, 5 staff (CNAs #12, #13, #14, #15 and #16) had not been retrained on 3 South, and 2 staff (CNAs #17 and #18) had not been retrained on 2 North.

Interview with Qualified Developmental Disabilities Professional (QDDP) #7 and administrative staff #4 on 9/14/11 at 10:30

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	AM indicated the CNAs, nursing staff and himself were retrained in regard to restraint techniques on 8/31 and/or 9/1/11. QDDP #7 stated it was felt clients G and I's bruises were from staff using "inappropriate escort techniques." QDDP #7 stated "The whole building was being trained and did not finish until the end of the month." Interview with administrative staff #2 on 9/14/11 at 1:40 PM indicated she could not locate documented training for CNAs #10, #11, #12, #13, #14, #15, #16, #17 and #18 in regard to the staff being retrained in regard to the appropriate physical intervention techniques. 3.1-13(b)(2)			
W0210	Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review, the facility failed to reassess 1 of 5 sampled client's dietary recommendations for triple portions when the client's weight exceeded his ideal body weight (client A). Findings include: During the 09/13/2011 observation period between 7:05 AM and 9:20 AM, at the facility, at 8:10	W0210	W 210 Individual Program Plan Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.	10/15/2011

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	a.m., client A ate 2 sausage patties, 3 pancakes, 3 butter packets, 2 individual sized syrups and drank 1/2 cup of orange juice for breakfast. Client A's record was reviewed on 09/13/2011 at 2:39 p.m. Physician's orders, dated, 08/30/2011, indicated, "...Diet Type: Regular...give diet pudding and 1/2 sandwich at 2 p.m. snack...triple portions at meals due to weight loss GIVE ONLY 4 OZ (ounces) JUICE AT BREAKFAST D/T (due to) DIABETES...GIVE 6 OZ YOGURT AT 10 AM IF MORNING BLOOD SUGAR IS 200 OR LESS...1 whole meat sandwich with double meat at h.s. (bedtime) for satiety (weight loss)...Monthly Weight...." A Progress Note, dated 08/28/2011, indicated, "...Dietary note. Client's current weight is 143.8# (pounds)...IBWR (Ideal Body Weight Range) is 117-143#...Diet is Regular - triple portions at meals due to weight loss...." Client A's weight record was reviewed on 09/13/2011 at 4:45 p.m. Weights included: 149.4 pounds in March 2011, no weight recorded in April 2011, 145.5 pounds in May 2011, 145.5 pounds in June 2011, 143.8 pounds in July 2011, 143.8 pounds in August 2011, and 151.6 pounds in September 2011. There was no documentation to indicate the IDT (Interdisciplinary Team) reassessed the the need for triple portions after client A exceeded ideal body weight for at least six months. During an interview on 09/14/2011 at 11:50 a.m., QDDP (Qualified Developmental Disabilities Professional) #7, QDDP #8 and QDDP #9 indicated they were not sure why triple portions		I Corrective Action for Cited Clients: Dietary and IDT will determine that the goal matches the need for client A. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: Dietary will review all resident goals they have written to assure they accurately reflect the need of that resident. IV Monitoring Corrective Measures: A weekly dietary meeting which includes program staff will discuss and review diets and goals for each unit as oversight. To be completed by 10-15-11.	

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	had been ordered for client A. The dietitian was not available to interview. This federal tag relates to complaint #IN00095883. 3.1-31(a) 3.1-31(d)			
W0249	As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 1 of 5 sampled clients (D), the facility failed to ensure a client's Individual Support Plan (ISP) objectives and/or supports for meals were implemented as written. Finding include: The facility's incident reports and/or investigations were reviewed on 9/12/11 at 2:21 PM. The facility's 9/2/11 reportable incident report indicated "Staff notices [client D] running to his room, client had his hands around his neck and was coughing. Staff encouraged client to keep on coughing. Client kept on coughing until he couldn't cough no more. Staff then called the nurses and started performing heimlich maneuver as soon as	W0249	W 249 Program Implementation As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. I Corrective Action for Cited Clients:	10/15/2011

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	the nurses got there the food expelled. The food that was expelled was hamburger...[Client D] was on a regular diet and was eating appropriate diet when he choked...." The 9/2/11 reportable incident report indicated client D's doctor was contacted and an x-ray was obtained which found a "...possible early infiltrate to the right lung base...." The reportable incident report indicated client D was started on Cipro antibiotic for 10 days and client D's diet was changed to a mechanical soft diet with ground meat and no raw vegetables until the client could be evaluated by a Speech Therapist. During the 9/13/11 observation period between 7:05 AM and 9:20 AM, at the facility, facility staff did not stay at the table while client D ate his breakfast which consisted of ground sausage and hot cereal. Client D ate the ground sausage and the hot cereal with a spoon in a fast manner without redirection to slow down and/or to take smaller bites while Qualified Developmental Disabilities Professional (QDDP) #8 helped client C place food on his plate. After which, QDDP #8 left the table/area. CNA (Certified Nurse Aide) #5 then came over to the table and stood by client D. Another client, who was sitting at the table, client F handed CNA a bowl for pancakes as the bowl was empty. CNA		Client D's staff have been retrained on his dining goal with emphasis on him staying in the dining room until he has finished eating. II Other Clients Potentially at Risk: All client's have the potential to be affected by this deficient practice. III Corrective Measures or Systemic Changes: The Dining checklist has been modified to include dining goals and QMRPs and Social Workers have been trained in completing this new step. IV Monitoring Corrective Measures: Program Directors complete the dining audit weekly. To be completed by 10-15-11.	

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	#5 left the table and went to the hot food table to retrieve more pancakes. By the time CNA #5 returned to the table, client D had finished eating, stood and walked out of the dining room. Client D walked past a classroom, where one staff was located, went to his bedroom at the end of the hallway and got into bed. Client D's record was reviewed on 9/13/11 at 2:38 PM. Client D's 9/3/11 Interdisciplinary Team (IDT) Plan of Care Addendum indicated "Team met today to discuss [client D's] choking incident that occurred on 9/2/11 during dinner...Speech came and evaluated [client D] on 9/3/11 during lunch. She recommended that he go back to mechanical soft diet with no hamburgers, ground meat in sandwiches, and no raw vegetables. Team Recommendations are as follows: - A staff member is to sit with [client D] at all meals and monitor his rate of consumption...." Client D's 2/7/11 ISP indicated client D had an objective to slow his rate of consumption. Client D's 2/7/11 ISP objective methodology indicated "[Client D] was reported to have choked because he was eating so fast." The methodology indicated "During meals, explain to [client D] about safe eating skills. Prompt him as needed to use his baby spoon to eat			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G079	A. BUILDING 00 B. WING	09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	slowly...." The CNAs did not implement and/or encourage client D to slow his rate of consumption and/or sit next to the client while eating when opportunities for training existed. Interview with CNA #6 on 9/13/11 at 8:40 AM stated "He (client D) has to have staff with him. He eats very quick." Interview with QDDP #7 on 9/14/11 at 11:13 AM indicated client D had a history of getting up from the dining room table to leave while the client still had food in his mouth/chewing. Interview with QDDP #8 on 9/14/11 at 11:15 AM stated there was a "miscommunication" in regard to how client D was to be monitored at the 9/13/11 breakfast meal. QDDP #8 indicated the IDT determined facility staff should be at the table with client D when he ate his meals to redirect the client to slow down when eating. QDDP #8 indicated client D should have been redirected to the classroom after eating versus going to his bedroom to lay down. 3.1-32(a) 3.1-33(a) 3.1-37(a)			